



## PPO 1000 Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit Vontier Employment Services Human Resource Department or call 1-833-805-7672. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-833-805-7672 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>Network</u> : \$1,000 Individual / \$2,000 Family <u>Non-Network</u> : \$2,000 Individual / \$4,000 Family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive Care</u> and primary care services with <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<u>Are there other deductibles for specific services?</u>	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
<u>What is the out-of-pocket limit for this plan?</u>	For <u>network provider</u> : \$5,000 Individual / \$10,000 Family For <u>out-of-network providers</u> : \$12,000 Individual / \$24,000 Family per calendar year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain prior authorization for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-833-805-7672 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	40% <u>coinsurance</u>	Virtual visit – in-network \$20 <u>copay</u> per visit by a Designated Virtual <u>Network Provider</u> . No virtual visit coverage for out of <u>network</u> . If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-ins may apply.
	<u>Specialist</u> visit	\$60 <u>copay</u> /visit	40% <u>coinsurance</u>	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for certain services or \$300 penalty applies.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> <b>More information about <u>prescription drug coverage</u> is available at <a href="http://VontierBenefits.com">VontierBenefits.com</a></b>	Generic Drugs (Tier 1)	Retail: \$10 copay Mail Order: \$20 copay	Not Covered	Up to a 30-day maximum for retail scripts; 90-day maximum for mail scripts; utilization management required for certain drugs; all cost-sharing may be waived for certain ACA mandated preventive drugs. Specialty drugs have a \$0 copay under Prudent; if opted out of Prudent, specialty drug cost share is 30%.
	Preferred brand drugs (Tier 2)	Retail: 20% coinsurance, \$50 minimum, \$100 maximum; Mail: 20% coinsurance, \$125 minimum, \$250 maximum	Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail: 35% coinsurance, \$80 minimum, \$200 maximum, Mail: 35% coinsurance, \$200 minimum, \$500 maximum	Not Covered	
	Specialty drugs (Tier 4)	Same as other drug tiers	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or \$300 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	None
	<u>Emergency medical transportation</u>	No charge	No charge	None
	<u>Urgent care</u>	\$75 <u>copay</u> /visit	40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or \$300 penalty applies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <u>copay</u> /visit	40% <u>coinsurance</u>	Prior <u>Authorization</u> required for certain services out-of-network or \$300 penalty applies. Partial <u>Hospitalization</u> /Intensive outpatient treatment and Intensive Behavioral Therapy (ABA) In-network 20% after <u>plan</u> level <u>deductible</u> and out-of-network 40% after <u>plan</u> level <u>deductible</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior <u>Authorization</u> required out-of-network for inpatient facility or \$300 penalty applies.
<b>If you are pregnant</b>	Office visits	\$30 <u>copay</u> /initial visit only	40% <u>coinsurance</u>	Prior <u>Authorization</u> required for out-of-network for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean or \$300 penalty applies. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound)
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 visits per calendar year for <u>Home Health Care</u> . Prior <u>Authorization</u> required out-of-network for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN) or \$300 penalty applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit	40% <u>coinsurance</u>	Limited to 100 visits per calendar year physical, speech, and occupational combined.
	<u>Habilitation services</u>	\$30 <u>copay</u> /visit	40% <u>coinsurance</u>	<u>Habilitation Services</u> are provided, and limits are combined with <u>Rehabilitation Services</u> above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network or \$300 penalty applies.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required out-of-network for DME over \$1,000 or \$300 penalty applies.
	<u>Hospice services</u>	No charge	No charge	<u>Prior Authorization</u> required out-of-network before admission for an inpatient stay in a hospice facility or \$300 penalty applies.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	1 exam per year
	Children's glasses	Not covered	Not covered	Child glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Child dental check-up is not covered.

#### Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Adult routine vision exam (i.e. refraction)</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Weight loss programs</li> </ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-833-805-7672 or visit [www.myuh.com](http://www.myuh.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform).

**Does this [plan](#) provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

**Does this [plan](#) meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-805-7672.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-805-7672.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-833-805-7672.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-833-805-7672 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-805-7672.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-833-805-7672.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-833-805-7672.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-833-805-7672.

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

**This EXAMPLE event includes services like:**

Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

**Total Example Cost**      \$12,700

**In this example, Peg would pay:**

#### Cost Sharing

<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300

#### *What isn't covered*

Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,370</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

**Total Example Cost**      \$5,600

**In this example, Joe would pay:**

#### Cost Sharing

<u>Deductibles</u>	\$100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0

#### *What isn't covered*

Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$4,800</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

**Total Example Cost**      \$2,800

**In this example, Mia would pay:**

#### Cost Sharing

<u>Deductibles</u>	\$400
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0

#### *What isn't covered*

Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$910</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: UnitedHealthcare .